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103D CONGRESS
1ST SESSION

H. R. 3115

To improve access, affordability, and competition in health care, through the implementation of flexible savings accounts and malpractice reform, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 22, 1993

Mr. DREIER introduced the following bill; which was referred jointly to the Committees on Ways and Means, Energy and Commerce, and the Judiciary

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A BILL

To improve access, affordability, and competition in health care, through the implementation of flexible savings accounts and malpractice reform, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Competitive Affordable Health Care Act of 1993''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—TAX PROVISIONS ENCOURAGING LOW-COST HEALTH PLANS AND HEALTH CARE SAVINGS ACCOUNTS

SEC. 101. REFUNDABLE TAX CREDIT FOR INDIVIDUALS NOT COVERED UNDER EMPLOYER-PROVIDED HEALTH PLAN.

(a) REFUNDABLE CREDIT.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 37 and by inserting after section 34 the following new section:

"SEC. 35. QUALIFIED HEALTH CARE COSTS.

''(a) ALLOWANCE OF CREDIT.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to 15 percent of the lesser of—

''(1) the health care expenses of the taxpayer, or

''(2) the maximum health care expense amount.

''(b) MAXIMUM HEALTH CARE EXPENSE AMOUNT.—The maximum health care expense amount for any taxable year is—

''(1) $1,250 in the case of a taxpayer who is allowed only 1 exemption amount under section 151,

''(2) $2,500 in the case of a taxpayer who is allowed only 2 exemption amounts under section 151, and

''(3) $4,750 in the case of a taxpayer who is allowed 3 or more exemption amounts under section 151.

''(c) DEFINITIONS.—For purposes of this section—

''(1) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means any individual who is not covered under any employer-provided health plan. Such term shall not include an individual for whom an election under section 220 is in effect for the taxable year.

''(2) HEALTH CARE EXPENSES.—The term 'health care expenses' means the amount paid during the taxable year which would be allowable as a deduction for the taxable year under section 213 but

for the threshold based on adjusted gross income and subsection (e) of this section.

''(d) DOLLAR AMOUNTS ADJUSTED FOR INFLATION.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year beginning after the date of the enactment of this section, each dollar amount in subsection (b) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in the taxable year begins, by substituting the calendar year which includes the date of the enactment of this section for the calendar year referred to in subparagraph (B) thereof.

''(2) ROUNDING.—If any dollar amount as increased under paragraph (1) is not a multiple of $10, such dollar amount shall be rounded to the nearest multiple of $10 (or, if such dollar amount is a multiple of $5 and not of $10, such dollar amount shall be increased to the nearest multiple of $10).

''(e) DENIAL OF MEDICAL EXPENSE DEDUCTION FOR CREDITED AMOUNTS.—Any amount for which a credit is allowed under this section shall not be taken into ac-

count in computing the amount allowable as a deduction under section 213(a).''

(b) ALTERNATIVE DEDUCTION.—

(1) IN GENERAL.—Part VII of subchapter B of chapter 1 of such Code is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"**SEC. 220. QUALIFIED HEALTH CARE COSTS.**

''(a) ALLOWANCE OF DEDUCTION.—At the election of an eligible individual for the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the lesser of—

''(1) the health care expenses of the taxpayer, or

''(2) the maximum health care expense amount.

''(b) DEFINITIONS.—For purposes of this section, terms used in this section which are also used in section 35 shall have the respective meanings given such terms in section 35.

''(c) DENIAL OF MEDICAL EXPENSE DEDUCTION FOR DEDUCTED AMOUNTS.—Any amount for which a deduction is allowed under this section shall not be taken into account in computing the amount allowable as a deduction under section 213(a).''

(2) DEDUCTION ALLOWABLE WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by adding after paragraph (15) the following new paragraph:

''(16) HEALTH INSURANCE COSTS.—The deduction allowed by section 220.''

(c) REPEAL OF SEPARATE DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS.—Subsection (l) of section 162 of such Code is hereby repealed.

(d) CLERICAL AMENDMENTS.—

(1) Subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the last item and inserting the following new item:

''Sec. 35. Qualified health care costs.
''Sec. 36. Overpayments of tax.''

(2) Part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

''Sec. 220. Qualified health care costs.
''Sec. 221. Cross reference.''

SEC. 102. LIMITATION ON EXCLUSION FOR EMPLOYER-PROVIDED HEALTH COVERAGE.

(a) IN GENERAL.—The text of section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended to read as follows:

''(a) IN GENERAL.—Gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) LIMITATION.—The amount excludable from gross income under subsection (a) shall not exceed the value of the coverage under the lowest-cost available market health plan (as defined in section 137(c)(4)) available to the employer.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 103. HEALTH CARE SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

''SEC. 137. HEALTH CARE SAVINGS ACCOUNTS.

''(a) EXCLUSION.—Gross income of an employee shall not include any amount contributed during the taxable year by the employer to a health care savings account of such employee.

''(b) LIMITATIONS.—

''(1) MAXIMUM EXCLUSION.—Subsection (a) shall not apply to the extent that the amount contributed to a health care savings account for the tax-

able year exceeds the cost of the lowest cost available market health plan.

''(2) EMPLOYEE MUST HAVE CATASTROPHIC COVERAGE.—

''(A) IN GENERAL.—Subsection (a) shall not apply to any employee unless such employee has minimum catastrophic coverage throughout such taxable year for such employee, such employee's spouse, and each dependent (as defined in section 152) of such employee.

''(B) MINIMUM CATASTROPHIC COVERAGE.—For purposes of subparagraph (A), the term 'minimum catastrophic coverage' means an insurance plan which pay a minimum of 80 percent of all emergency care expenses per year to the extent such expenses incurred during such year exceed $4,000.

''(3) EXCLUSION LIMITED TO EMPLOYEES WITHOUT OTHER EMPLOYER-PROVIDED HEALTH BENEFITS.—This section shall not apply to any employee for the taxable year if any amount is excludable from the gross income of such employee under section 106 for such taxable year.

''(c) DEFINITIONS.—For purposes of this section—

''(1) HEALTH CARE SAVINGS ACCOUNT.—The term 'health care savings account' means a trust created or organized in the United States exclusively for the purpose of paying the health care expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

''(A) No contribution will be accepted unless it is in cash.

''(B) The trustee is a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

''(C) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(2) HEALTH CARE EXPENSES.—The term 'health care expenses' means, with respect to the account beneficiary, the amount paid by such beneficiary during the taxable year which would be allowable as a deduction for the taxable year under sec-

tion 213 but for the threshold based on adjusted gross income.

''(3) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the employee for whose benefit the health care savings account is established.

''(4) LOWEST COST AVAILABLE MARKET HEALTH PLAN.—The term 'lowest cost available market health plan' means the regional price of the lowest cost health insurance plan containing a minimum level of health care benefits (as determined by the Secretary of Health and Human Services).

''(d) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) IN GENERAL.—Any amount paid or distributed out of a health care savings account shall be included in the gross income of the individual for whose benefit such account was established unless such amount is used exclusively to pay the health care expenses of such individual.

''(2) PENALTY FOR AMOUNTS INCLUDED IN INCOME BEFORE THE CLOSE OF CALENDAR YEAR.—If any amount is includible in the gross income of the account beneficiary before the last business day during the taxable year, such beneficiary's tax imposed

by this chapter shall be increased by 10 percent of the amount so includible.

''(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—Paragraph (1) shall not apply to the distribution of any contribution paid during a taxable year to a health care savings account to the extent that such contribution exceeds the amount excludable under subsection (a) if—

''(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

''(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in subparagraph (B) shall be included in the gross income of the individual for the taxable year in which it is received.

''(e) TAX TREATMENT OF ACCOUNTS.—

''(1) ACCOUNT TAXED AS GRANTOR TRUST.—The individual for whose benefit a health care savings account is established shall be treated for purposes of this title as the owner thereof and shall be subject to tax thereon in accordance with subpart E

of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

''(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

''(A) IN GENERAL.—If, during any taxable year of the individual for whose benefit the health care savings account was established, such individual engages in any transaction prohibited by section 4975 with respect to the account, the account ceases to be a health care savings account as of the first day of that taxable year.

''(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a health care savings account by reason of subparagraph (A) on the first day of any taxable year, paragraph (1) of subsection (h) shall be applied as if there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day) and no portion of such distribution were used to pay health care expenses.

''(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the individual for whose benefit a health care savings account was established uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed to that individual and not used to pay health care expenses.

''(f) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

''(1) the assets of such account are held by a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer the account will be consistent with the requirements of this section, and

''(2) the custodial account would, except for the fact that it is not a trust, constitute a health care savings account described in subsection (g).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

''(g) REPORTS.—The trustee of a health care savings account shall make such reports regarding such account to the Secretary and to the individual for whose benefit

the account is maintained with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations.

''(h) OTHER DEFINITIONS.—For purposes of this section—

''(1) EMPLOYER.—The term 'employer' includes persons treated as an employer under section 401(c)(4).

''(2) EMPLOYEE.—The term 'employee' includes—

''(A) an individual who is an employee within the meaning of section 401(c)(1), and

''(B) former employees.

''(3) TYPE OF COVERAGE.—The types of coverage are—

''(A) self-only coverage, and

''(B) coverage other than self-only coverage.

''(4) HEALTH INSURANCE PLAN.—The term 'health insurance plan' means any contract or arrangement under which an insurer bears all or part of the cost or risk of providing health care items and

services, including a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract (including any self-insured health insurance plan), but does not include—

''(A) coverage only for accident, dental, vision, disability, or long term care, medicare supplemental health insurance, or any combination thereof,

''(B) coverage issued as a supplement to liability insurance,

''(C) workers' compensation or similar insurance, or

''(D) automobile medical-payment insurance.''

(b) EXCLUSION APPLIES FOR EMPLOYMENT TAX PURPOSES.—

(1) SOCIAL SECURITY TAXES.—

(A) Paragraph (20) of section 3121(a) of such Code is amended by striking ''or 132'' and inserting ''132, or 137''.

(B) Paragraph (17) of section 209(a) of the Social Security Act is amended by striking ''or 132'' and inserting ''132, or 137''.

(2) RAILROAD RETIREMENT TAX.—Paragraph (5) of section 3231(e) of such Code is amended by striking ''or 132'' and inserting ''132, or 137''.

(3) UNEMPLOYMENT TAX.—Paragraph (16) of section 3306(b) of such Code is amended by striking ''or 132'' and inserting ''132, or 137''.

(4) WITHHOLDING TAX.—Paragraph (19) of section 3401(a) of such Code is amended by striking ''or 132'' and inserting '', 132, or 137''.

(c) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''**HEALTH CARE SAVINGS ACCOUNTS,**'' after ''**ACCOUNTS,**'' in the heading of such section,

(2) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a health care savings account (within the meaning of section 137(g)),'',

(3) by striking ''or'' at the end of paragraph (1) of subsection (a), and

(4) by adding at the end thereof the following new subsection:

''(d) EXCESS CONTRIBUTIONS TO HEALTH CARE SAVINGS ACCOUNTS.—For purposes of this section, in the case of a health care savings account (within the meaning of section 137(g)), the term 'excess contributions' means the amount by which the amount contributed for the taxable year to the account exceeds the amount excludable from gross income under section 137 for such taxable year. For purposes of this subsection, any contribution which is distributed out of the health care savings account in a distribution to which section 137(h)(2) applies shall be treated as an amount not contributed.''

(d) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of such Code (relating to prohibited transactions) is amended—

(1) by adding at the end of subsection (c) the following new paragraph:

''(4) SPECIAL RULE FOR HEALTH CARE SAVINGS ACCOUNTS.—An individual for whose benefit a health care savings account (within the meaning of section 137(g)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with re-

spect to such transaction, the account ceases to be a health care savings account by reason of the application of section 137(h)(2)(A) to such account.'', and

(2) by inserting ''or a health care savings account described in section 137(g)'' in subsection (e)(1) after ''described in section 408(a)''.

(e) FAILURE TO PROVIDE REPORTS ON HEALTH CARE SAVINGS ACCOUNTS.—Section 6693 of such Code (relating to failure to provide reports on individual retirement account or annuities) is amended—

(1) by inserting ''**OR ON HEALTH CARE SAVINGS ACCOUNTS**'' after ''**ANNUITIES**'' in the heading of such section, and

(2) by adding at the end of subsection (a) the following: ''The person required by section 137(g) to file a report regarding a health care savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.''

(f) HEALTH CARE SAVINGS ACCOUNT CONTRIBUTIONS NOT SUBJECT TO WELFARE BENEFIT FUND RULES.—Paragraph (2) of section 419(e) of such Code (defining welfare benefit) is amended by striking ''or'' at

the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting ‘‘, or’’, and by adding at the end thereof the following new subparagraph:

‘‘(D) section 137 applies.’’

(g) CLERICAL AMENDMENTS.—

(1) The table of sections for part III of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

‘‘Sec. 137. Health care savings accounts.
‘‘Sec. 138. Cross references to other Acts.’’

(2) The table of sections for chapter 43 of such Code is amended by striking the item relating to section 4973 and inserting the following:

‘‘Sec. 4973. Tax on excess contributions to individual retirement accounts, health care savings accounts, certain 403(b) contracts, and certain individual retirement annuities.’’

(3) The table of sections for subchapter B of chapter 68 of such Code is amended by inserting ‘‘or on health care savings accounts’’ after ‘‘annuities’’ in the item relating to section 6693.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the close of the calendar year which includes the date of the enactment of this Act.

TITLE II—HEALTH CARE COST CONTAINMENT

Subtitle A—Health Care Liability Reform

SEC. 201. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any health care liability claim and to any health care liability action brought in any State or Federal court (except as provided in section 203), except that this subtitle shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action.

(b) PREEMPTION OF STATE LAW.—Subject to section 208, this subtitle supersedes State law only to the extent that State law differs from any provision of law established by or under this subtitle. Any issue that is not governed by any provision of law established by or under this subtitle shall be governed by otherwise applicable State or Federal law.

(c) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over health care

liability actions on the basis of sections 1331 or 1337 of title 28, United States Code.

SEC. 202. STATUTE OF LIMITATIONS.

(a) IN GENERAL.—No health care liability claim may be brought against any party after the expiration of the 10-year period that begins on the date the party committed the action which caused the alleged injury that is the subject of the claim.

(b) EXCEPTION FOR CLAIMS BASED ON INTENTIONAL ACTION.—Subsection (a) shall not apply to a claim brought against a party if the claimant's sole allegation is an allegation of an intentional tort.

SEC. 203. REQUIREMENT FOR INITIAL RESOLUTION OF ACTIONS IN FEDERAL COURT THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) REQUIREMENT.—

(1) IN GENERAL.—No health care liability action may be brought in any Federal court during a calendar year unless the health care liability claim that is the subject of the action has been initially resolved under the alternative dispute resolution system established by the Secretary under subsection (b).

(2) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of paragraph (1), an action is

''initially resolved'' under an alternative dispute resolution system if—

(A) the ADR reaches a decision on whether the defendant is liable to the plaintiff for damages; and

(B) if the ADR determines that the defendant is liable, the ADR reaches a decision on the amount of damages assessed against the defendant.

(3) EXCLUSION OF COURTS OF DISTRICT OF COLUMBIA.—For purposes of paragraph (1), the term ''Federal court'' does not include the Superior Court of the District of Columbia or the District of Columbia Court of Appeals.

(b) ESTABLISHMENT OF SYSTEM.—

(1) IN GENERAL.—The Attorney General shall establish an alternative dispute resolution system that meets the requirements of paragraph (2) for the resolution of health care liability claims under the jurisdiction of the Federal courts.

(2) REQUIREMENTS DESCRIBED.—The ADR system established by the Attorney General under paragraph (1) meets the requirements of this paragraph if the system—

(A) applies to all health care liability claims under the jurisdiction of the Federal courts;

(B) requires that a written opinion resolving the dispute be issued not later than 6 months after the date by which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(i) findings of fact relating to the dispute, and

(ii) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

(C) provides that claims brought under the system shall be heard and resolved by arbitrators appointed by the Secretary in consultation with the Attorney General;

(D) requires all parties to present (or to make all reasonable efforts to present) all rel-

evant information relating to the claim to the arbitrator, and permits the arbitrator to request the court of relevant jurisdiction to impose criminal penalties against any party that knowingly or intentionally fails to present (or to make all reasonable efforts to present) such information;

(E) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings a health care liability action contesting the decision made under the system; and

(F) provides for the regular transmittal to the Administrator for Health Care Policy and Research of information on disputes resolved under the system, in a manner that assures that the identity of the parties to a dispute shall not be revealed.

(c) APPLICATION OF HEALTH CARE LIABILITY STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—The provisions of this subtitle shall apply with respect to claims brought under the alternative dispute resolution system established under this section in the same manner as such provisions apply with respect to health care liability actions.

(d) RULES FOR HEALTH CARE LIABILITY ACTIONS CONTESTING ADR RULING.—

(1) REQUIRING PARTY CONTESTING ADR RULING TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

(A) IN GENERAL.—In each health care liability action brought in a Federal court, the court shall require the party that contested the ruling of the alternative dispute resolution system with respect to the health care liability claim that is the subject of the action to pay to the opposing party the costs incurred by the opposing party under the action, including attorney's fees, fees paid to expert witnesses, and other litigation expenses (but not including any fees or costs associated with the resolution of the claim under the alternative dispute resolution system).

(B) EXCEPTIONS.—Subparagraph (A) shall not apply if—

(i) the party contesting the ruling made under the previous alternative dispute resolution system shows that—

(I) the ruling was procured by corruption, fraud, or undue means,

(II) there was partiality or corruption under the system,

(III) there was other misconduct under the system that materially prejudiced the party's rights, or

(IV) the ruling was based on an error of law;

(ii) the party contesting the ruling made under the previous alternative dispute resolution system presents new evidence before the trier of fact that was not available for presentation under the ADR system; or

(iii) the court finds that the application of such paragraph to a party would constitute an undue hardship, and issues an order waiving or modifying the applica-

tion of such paragraph that specifies the grounds for the court's decision.

(2) RESTRICTIONS ON EVIDENCE PRESENTED.—In any health care liability action brought in a Federal court, no party may present any evidence to the court that the party did not present during the previous proceeding under the alternative dispute resolution system unless the court finds that—

(A) the party could not reasonably have been aware of the existence of such evidence or its availability for presentation at the time of the ADR proceeding; or

(B) the restriction against the ability of the party to present such evidence would constitute an undue hardship against the party.

(e) ESTABLISHMENT OF MODEL STATE SYSTEM.—Not later than 4 years after the date of the enactment of this Act, the Secretary (in consultation with the Attorney General) shall establish a model alternative dispute resolution system that a State may (at its option) apply to health care liability claims under the jurisdiction of its courts.

SEC. 204. CALCULATION AND PAYMENT OF DAMAGES.

(a) LIMITATION ON NONECONOMIC DAMAGES.—

(1) IN GENERAL.—Subject to paragraph (2), the total amount of noneconomic damages that may be awarded to a plaintiff and the members of the plaintiff's family for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(2) MAXIMUM LIABILITY.—The maximum amount of the liability of any defendant for any event, action, or product with respect to all plaintiffs (and potential plaintiffs) in a health care liability action for noneconomic damages may not exceed $1,000,000.

(b) ALLOCATION OF PUNITIVE DAMAGES TO UNINSURED RISK POOL.—Of the total amount of punitive damages imposed under a health care liability action—

(1) 15 percent shall be paid to the plaintiff; and

(2) 85 percent shall be paid to the United States for the deposit into the Treasury as miscellaneous revenues (for the purpose of financing of tax credits provided under section 35 of the Internal Revenue Code of 1986).

SEC. 205. TREATMENT OF ATTORNEY'S FEES.

If the plaintiff in a health care liability action has entered into an agreement with the plaintiff's attorney to pay the attorney's fees on a contingency basis, the attorney's fees for the action may not exceed—

(1) 30 percent of the first $100,000 of any award or settlement paid to the plaintiff;

(2) 20 percent of the next $100,000 of such award or settlement paid to the plaintiff; or

(3) 10 percent of any additional amounts paid to the plaintiff.

SEC. 206. JOINT AND SEVERAL LIABILITY.

The liability of each defendant in a health care liability action shall be several only and shall not be joint, and each defendant shall be liable only for the amount of damages allocated to the defendant in direct proportion to the defendant's percentage of responsibility (as determined by the trier of fact).

SEC. 207. MANDATORY OFFSETS FOR DAMAGES PAID BY A COLLATERAL SOURCE.

(a) IN GENERAL.—The total amount of damages received by a plaintiff in a health care liability action shall be reduced (in accordance with subsection (b)) by any other payment that has been or will be made to the individual to compensate the plaintiff for the injury that was the subject of the action, including payment under—

(1) Federal or State disability or sickness programs;

(2) Federal, State, or private health insurance programs;

(3) private disability insurance programs;

(4) employer wage continuation programs; and

(5) any other source of payment intended to compensate the plaintiff for such injury.

(b) AMOUNT OF REDUCTION.—The amount by which an award of damages to a plaintiff shall be reduced under subsection (a) shall be—

(1) the total amount of any payments (other than such award) that have been made or that will be made to the plaintiff to compensate the plaintiff for the injury that was the subject of the action; minus

(2) the amount paid by the plaintiff (or by the spouse, parent, or legal guardian of the plaintiff) to secure the payments described in paragraph (1).

SEC. 208. PREEMPTION.

(a) IN GENERAL.—This subtitle supersedes any State law only to the extent that State law—

(1) permits the recovery of a greater amount of damages by a plaintiff;

(2) permits the collection of a greater amount of attorneys' fees by a plaintiff's attorney; or

(3) establishes a longer period during which a health care liability claim may be initiated.

(b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (a) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

SEC. 209. DEFINITIONS.

As used in this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means the system established by the Attorney General under section 203 that provides for the resolution of health care liability claims under the jurisdiction of the Federal courts in a manner other than through health care liability actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a health care liability claim, or, in the case of an individual who is deceased, incompetent, or a minor, the person on whose behalf such a claim is alleged.

(3) ECONOMIC DAMAGES.—The term ''economic damages'' means damages paid to compensate an individual for losses for hospital and other medical expenses, lost wages, lost employment, and other pecuniary losses.

(4) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action (other than an action in which the plaintiff's sole allegation is an allegation of an intentional tort) brought in a State or Federal court against a health care provider or health care professional (regardless of the theory of liability on which the action is

based) in which the plaintiff alleges a health care liability claim, and includes an action in which the plaintiff alleges harm arising from the use of a medical product.

(5) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services or the use of a medical product.

(6) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by State law or regulation to be licensed or certified by the State to provide such services in the State.

(7) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(8) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a health care liability action or claim.

(9) MEDICAL PRODUCT.—The term ''medical product'' means a device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) or a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act).

(10) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to compensate an individual for losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, and other nonpecuniary losses, but does not include punitive damages.

(11) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(12) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

SEC. 210. EFFECTIVE DATE.

This subtitle shall apply with respect to claims accruing or actions brought on or after the expiration of the 1-year period that begins on the date of the enactment of this Act.

Subtitle B—Limit on Self-Referrals by Health Care Provider

SEC. 221. LIMITATION ON SELF-REFERRALS BY HEALTH CARE PROVIDERS.

(a) IN GENERAL.—If a health care provider refers a patient to any facility in which the provider (or a family member) has a financial interest for the performance of any health care service, the provider—

(1) must disclose to the patient the nature of such interest;

(2) must present the patient with a list of the 3 closest reasonably known available facilities which perform the service; and

(3) may not place undue pressure on the patient to obtain the service from the facility in which the provider (or a family member) has a financial interest.

(b) ENFORCEMENT.—

(1) INITIAL VIOLATION.—If a health care provider violates a requirement of subsection (a) and has not previously been subject to a sanction under this subsection, the provider is subject to a civil money penalty in an amount specified under subsection (c).

(2) SECOND VIOLATION.—If a health care provider violates a requirement of subsection (a) and has previously been subject to a sanction under this subsection, the provider is subject to—

(A) a civil money penalty in an amount specified under subsection (c), and

(B) a suspension of the right of the provider to provide health care services for a period of time specified under subsection (c).

(3) THIRD VIOLATION.—If a health care provider violates a requirement of subsection (a), and has previously been subject to a suspension under this subsection—

(A) the provider is subject to a civil money penalty in an amount specified under subsection (c), and

(B) the provider's right to provide health care services is permanently revoked.

(c) AMOUNT OF CIVIL MONEY PENALTY AND PERIOD OF SUSPENSION.—The amount of a civil money penalty under subsection (b) and the period of any suspension of the right to provide health care services under subsection (b) shall be established by the Secretary of Health and Human Services based upon the recommendations of the

National Association of Insurance Commissioners and other health care representatives.

(d) ENFORCEMENT PROCESS.—The Secretary of Health and Human Services shall establish a process for the imposition of sanctions under subsection (b).

(e) DEFINITIONS.—In this section:

(1) The term ''Secretary'' means the Secretary of Health and Human Services.

(2) The term ''financial interest'' includes any ownership, income rights, or other pecuniary interest.

(3) The term ''family member'' includes the spouse, child, grandchild, parent, or sibling, or spouse of such a child, grandchild, parent, or sibling.

(f) EFFECTIVE DATE.—This section shall apply to referrals made later than 1 year after the date of the enactment of this Act.

Subtitle C—Administrative Cost Savings

SEC. 230. DEFINITIONS.

For purposes of this subtitle:

(1) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance

subscriber contract, or a multiple employer welfare arrangement or employee benefit plan (as defined under the Employee Retirement Income Security Act of 1974) which provides benefits with respect to health care services. The term includes the medicare program (under title XVIII of the Social Security Act), medicare supplemental health insurance, and a State medicaid plan (approved under title XIX of such Act). The term does not include—

(A) coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof,

(B) coverage issued as a supplement to liability insurance,

(C) worker's compensation or similar insurance, or

(D) automobile medical-payment insurance,

or any combination thereof.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(3) STATE.—The term ''State'' means any of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

PART 1—STANDARDIZATION OF CLAIMS PROCESSING

SEC. 231. ADOPTION OF DATA ELEMENTS, UNIFORM CLAIMS, AND UNIFORM ELECTRONIC TRANSMISSION STANDARDS.

(a) IN GENERAL.—The Secretary shall adopt standards relating to each of the following:

(1) Data elements for use in paper and electronic claims processing under health benefit plans, as well as for use in utilization review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information).

(2) Uniform claims forms (including uniform procedure and billing codes for uses with such forms and including information on other health benefit plans that may be liable for benefits).

(3) Uniform electronic transmission of the data elements (for purposes of billing and utilization review).

Standards under paragraph (3) relating to electronic transmission of data elements for claims for services shall supersede (to the extent specified in such standards) the standards adopted under paragraph (2) relating to the submission of paper claims for such services. Standards under paragraph (3) shall include protections to assure

the confidentiality of patient-specific information and to protect against the unauthorized use and disclosure of information.

(b) USE OF TASK FORCES.—In adopting standards under this section—

(1) the Secretary shall take into account the recommendations of current taskforces, including at least the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force, and the Computer-based Patient Record Institute;

(2) the Secretary shall consult with the National Association of Insurance Commissioners (and, with respect to standards under subsection (a)(3), the American National Standards Institute); and

(3) the Secretary shall, to the maximum extent practicable, seek to make the standards consistent with any uniform clinical data sets which have been adopted and are widely recognized.

(c) DEADLINES FOR PROMULGATION.—The Secretary shall promulgate the standards under—

(1) subsection (a)(1) relating to claims processing data, by not later than 12 months after the date of the enactment of this Act;

(2) subsection (a)(2) (relating to uniform claims forms) by not later than 12 months after the date of the enactment of this Act; and

(3)(A) subsection (a)(3) relating to transmission of information concerning hospital and physicians services, by not later than 24 months after the date of the enactment of this Act, and

(B) subsection (a)(3) relating to transmission of information on other services, by such later date as the Secretary may determine it to be feasible.

(d) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary shall report to Congress recommendations regarding restructuring the medicare peer review quality assurance program given the availability of hospital data in electronic form.

SEC. 232. APPLICATION OF STANDARDS.

(a) IN GENERAL.—If the Secretary determines, at the end of the 2-year period beginning on the date that standards are adopted under section 231 with respect to classes of services, that a significant number of claims for benefits for such services under health benefit plans are not being submitted in accordance with such standards, the Secretary may require, after notice in the Federal Register of not less than 6 months, that all providers of

such services must submit claims to health benefit plans in accordance with such standards. The Secretary may waive the application of such a requirement in such cases as the Secretary finds that the imposition of the requirement would not be economically practicable.

(b) SIGNIFICANT NUMBER.—The Secretary shall make an affirmative determination described in subsection (a) for a class of services only if the Secretary finds that there would be a significant, measurable additional gain in efficiencies in the health care system that would be obtained by imposing the requirement described in such paragraph with respect to such services.

(c) APPLICATION OF REQUIREMENT.—

(1) IN GENERAL.—If the Secretary imposes the requirement under subsection (a)—

(A) in the case of a requirement that imposes the standards relating to electronic transmission of claims for a class of services, each health care provider that furnishes such services for which benefits are payable under a health benefit plan shall transmit electronically and directly to the plan on behalf of the beneficiary involved a claim for such services in accordance with such standards;

(B) any health benefit plan may reject any claim subject to the standards adopted under section 231 but which is not submitted in accordance with such standards;

(C) it is unlawful for a health benefit plan (i) to reject any such claim on the basis of the form in which it is submitted if it is submitted in accordance with such standards or (ii) to require, for the purpose of utilization review or as a condition of providing benefits under the plan, a provider to transmit medical data elements that are inconsistent with the standards established under section 231(a)(1); and

(D) the Secretary may impose a civil money penalty on any provider that knowingly and repeatedly submits claims in violation of such standards or on any health benefit plan (other than a health benefit plan described in paragraph (2)) that knowingly and repeatedly rejects claims in violation of subparagraph (B), in an amount not to exceed $100 for each such claim.

The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a

civil money penalty under subparagraph (D) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan—

(A) that is subject to regulation by a State; and

(B) with respect to which the Secretary finds that—

(i) the State provides for application of the standards established under section 231, and

(ii) the State regulatory program provides for the appropriate and effective enforcement of such standards.

(d) TREATMENT OF REJECTIONS.—If a plan rejects a claim pursuant to subsection (c)(1), the plan shall permit the person submitting the claim a reasonable opportunity to resubmit the claim on a form or in an electronic manner that meets the requirements for acceptance of the claim under such subsection.

SEC. 233. PERIODIC REVIEW AND REVISION OF STANDARDS.

(a) IN GENERAL.—The Secretary shall—

(1) provide for the ongoing receipt and review of comments and suggestions for changes in the standards adopted and promulgated under section 231;

(2) establish a schedule for the periodic review of such standards; and

(3) based upon such comments, suggestions, and review, revise such standards and promulgate such revisions.

(b) APPLICATION OF REVISED STANDARDS.—If the Secretary under subsection (a) revises the standards described in 231, then, in the case of any claim for benefits submitted under a health benefit plan more than the minimum period (of not less than 6 months specified by the Secretary) after the date the revision is promulgated under subsection (a)(3), such standards shall apply under section 232 instead of the standards previously promulgated.

PART 2—ELECTRONIC MEDICAL DATA STANDARDS

SEC. 241. MEDICAL DATA STANDARDS FOR HOSPITALS AND OTHER PROVIDERS.

(a) PROMULGATION OF HOSPITAL DATA STANDARDS.—

(1) IN GENERAL.—Between July 1, 1994, and January 1, 1995, the Secretary shall promulgate

standards described in subsection (b) for hospitals concerning electronic medical data.

(2) REVISION.—The Secretary may from time to time revise the standards promulgated under this subsection.

(b) CONTENTS OF DATA STANDARDS.—The standards promulgated under subsection (a) shall include at least the following:

(1) A definition of a standard set of data elements for use by utilization and quality control peer review organizations.

(2) A definition of the set of comprehensive data elements, which set shall include for hospitals the standard set of data elements defined under paragraph (1).

(3) Standards for an electronic patient care information system with data obtained at the point of care, including standards to protect against the unauthorized use and disclosure of information.

(4) A specification of, and manner of presentation of, the individual data elements of the sets and system under this subsection.

(5) Standards concerning the transmission of electronic medical data.

(6) Standards relating to confidentiality of patient-specific information.

The standards under this section shall be consistent with standards for data elements established under section 231.

(c) OPTIONAL DATA STANDARDS FOR OTHER PROVIDERS.—

(1) IN GENERAL.—The Secretary may promulgate standards described in paragraph (2) concerning electronic medical data for providers that are not hospitals. The Secretary may from time to time revise the standards promulgated under this subsection.

(2) CONTENTS OF DATA STANDARDS.—The standards promulgated under paragraph (1) for non-hospital providers may include standards comparable to the standards described in paragraphs (2), (4), and (5) of subsection (b) for hospitals.

(d) CONSULTATION.—In promulgating and revising standards under this section, the Secretary shall—

(1) consult with the American National Standards Institute, hospitals, with the advisory commission established under section 244, and with other affected providers, health benefit plans, and other interested parties, and

(2) take into consideration, in developing standards under subsection (b)(1), the data set used by the utilization and quality control peer review program under part B of title XI of the Social Security Act.

SEC. 242. APPLICATION OF ELECTRONIC DATA STANDARDS TO CERTAIN HOSPITALS.

(a) MEDICARE REQUIREMENT FOR SHARING OF HOSPITAL INFORMATION.—As of January 1, 1996, subject to paragraph (2), each hospital, as a requirement of each participation agreement under section 1866 of the Social Security Act, shall—

(1) maintain clinical data included in the set of comprehensive data elements under section 241(b)(2) in electronic form on all inpatients,

(2) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI of such Act), transmit electronically the data set, and

(3) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set, in accordance with the standards promulgated under section 241(a).

(b) WAIVER AUTHORITY.—Until January 1, 2000:

(1) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is a small rural hospital, for such period as the hospital demonstrates compliance with such requirements would constitute an undue financial hardship.

(2) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is in the process of developing a system to provide the required data set and executes agreements with its fiscal intermediary and its utilization and quality control peer review organization that the hospital will meet the requirements of subsection (a) by a specified date (not later than January 1, 2000).

(3) The Secretary may waive the application of the requirement of subsection (a)(1) for a hospital that agrees to obtain from its records the data elements that are needed to meet the requirements of paragraphs (2) and (3) of subsection (a) and agrees to subject its data transfer process to a quality assurance program specified by the Secretary.

(c) APPLICATION TO HOSPITALS OF THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall provide that each hospital of the De-

partment of Veterans Affairs shall comply with the requirements of subsection (a) in the same manner as such requirements would apply to the hospital if it were participating in the Medicare program.

(2) WAIVER.—Such Secretary may waive the application of such requirements to a hospital in the same manner as the Secretary of Health and Human Services may waive under subsection (b) the application of the requirements of subsection (a).

SEC. 243. ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.

(a) IN GENERAL.—Effective January 1, 2000, if a provider is required under a Federal program to transmit a data element that is subject to a presentation or transmission standard (as defined in subsection (b)), the head of the Federal agency responsible for such program (if not otherwise authorized) is authorized to require the provider to present and transmit the data element electronically in accordance with such a standard.

(b) PRESENTATION OR TRANSMISSION STANDARD DEFINED.—In subsection (a), the term ''presentation or transmission standard'' means a standard, promulgated under subsection (b) or (c) of section 241, described in paragraph (4) or (5) of section 241(b).

SEC. 244. ADVISORY COMMISSION.

(a) IN GENERAL.—The Secretary shall establish an advisory commission including hospital executives, hospital data base managers, physicians, health services researchers, and technical experts in collection and use of data and operation of data systems. Such commission shall include, as ex officio members, a representative of the Director of the National Institutes of Health, the Administrator for Health Care Policy and Research, the Secretary of Veterans Affairs, and the Director of the Centers for Disease Control.

(b) FUNCTIONS.—The advisory commission shall monitor and advise the Secretary concerning—

(1) the standards established under this part, and

(2) operational concerns about the implementation of such standards under this part.

(c) STAFF.—From the amounts appropriated under subsection (d), the Secretary shall provide sufficient staff to assist the advisory commission in its activities under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $2,000,000 for each of fiscal years 1994 through 1999 to carry out this section.

PART 3—DEVELOPMENT AND DISTRIBUTION OF COMPARATIVE VALUE INFORMATION

SEC. 251. STATE COMPARATIVE VALUE INFORMATION PROGRAMS FOR HEALTH CARE PURCHASING.

(a) PURPOSE.—In order to assure the availability of comparative value information to purchasers of health care in each State, the Secretary shall determine whether each State is developing and implementing a health care value information program that meets the criteria and schedule set forth in subsection (b).

(b) CRITERIA AND SCHEDULE FOR STATE PROGRAMS.—The criteria and schedule for a State health care value information program in this subsection shall be specified by the Secretary as follows:

(1) The State begins promptly after enactment of this Act to develop (directly or through contractual or other arrangements with one or more States, coalitions of health insurance purchasers, other entities, or any combination of such arrangements) information systems regarding comparative health values.

(2) The information contained in such systems covers at least the average prices of common health care services (as defined in subsection (d)) and health insurance plans, and, where available, meas-

ures of the variability of these prices within a State or other market areas.

(3) The information described in paragraph (2) is made available within the State beginning not later than 1 year after the date of the enactment of this Act, and is revised as frequently as reasonably necessary, but at intervals of no greater than 1 year.

(4) Not later than 6 years after the date of the enactment of this Act the State has developed information systems that provide comparative costs, quality, and outcomes data with respect to health insurance plans and hospitals and made the information broadly available within the relevant market areas.

Nothing in this section shall preclude a State from providing additional information, such as information on prices and benefits of different health benefit plans, available.

(c) GRANTS TO STATES FOR THE DEVELOPMENT OF STATE PROGRAMS.—

(1) GRANT AUTHORITY.—The Secretary may make grants to each State to enable such State to plan the development of its health care value information program and, if necessary, to initiate the implementation of such program. Each State seeking such a grant shall submit an application therefore, containing such information as the Secretary finds

necessary to assure that the State is likely to develop and implement a program in accordance with the criteria and schedule in subsection (b).

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to make grants under this subsection, to remain available until expended.

(d) COMMON HEALTH CARE SERVICES DEFINED.—In this section, the term ''common health care services'' includes such procedures as the Secretary may specify and any additional health care services which a State may wish to include in its comparative value information program.

SEC. 252. COMPARATIVE VALUE INFORMATION CONCERNING FEDERAL PROGRAMS.

(a) DEVELOPMENT.—The head of each Federal agency with responsibility for the provision of health insurance or of health care services to individuals shall promptly develop health care value information relating to each program that such head administers and covering the same types of data that a State program meeting the criteria of section 251(b) would provide.

(b) DISSEMINATION OF INFORMATION.—Such information shall be made generally available to States and to providers and consumers of health care services.

SEC. 253. DEVELOPMENT OF MODEL SYSTEMS.

(a) IN GENERAL.—The Secretary shall, directly or through grant or contract, develop model systems to facilitate—

(1) the gathering of data on health care cost, quality, and outcome described in section 251(b)(4), and

(2) analyzing such data in a manner that will permit the valid comparison of such data among providers and among health plans.

(b) EXPERIMENTATION.—The Secretary shall support experimentation with different approaches to achieve the objectives of subsection (a) in the most cost effective manner (relative to the accuracy and timeliness of the data secured) and shall evaluate the various methods to determine their relative success.

(c) STANDARDS.—When the Secretary considers it appropriate, the Secretary may establish standards for the collection and reporting of data on health care cost, quality and outcomes in order to facilitate analysis and comparisons among States and nationally.

(d) REPORT.—By not later than 3 years after the date of the enactment of this Act, the Secretary shall report to the Congress and the States on the models developed, and experiments conducted, under this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for each fiscal year beginning with fiscal year 1994 to enable the Secretary to carry out this section, including evaluation of the different approaches tested under subsection (b) and their relative cost effectiveness.

PART 4—ADDITIONAL STANDARDS AND REQUIREMENTS

SEC. 261. STANDARDS RELATING TO USE OF MEDICARE AND MEDICAID MAGNETIZED HEALTH BENEFIT CARDS; SECONDARY PAYER DATA BANK.

(a) MAGNETIZED IDENTIFICATION CARDS UNDER MEDICARE PROGRAM.—The Secretary shall adopt standards relating to the design and use of magnetized medicare identification cards in order to assist health care providers providing medicare covered services to individuals—

(1) in determining whether individuals are eligible for benefits under the medicare program, and

(2) in billing the medicare program for such services provided to eligible individuals.

Such cards shall be designed to be compatible with machines currently employed to transmit information on credit cards. Such cards also shall be designed to be able to be used with respect to the provision of benefits under medicare supplemental policies.

(b) ADOPTION UNDER MEDICAID PLANS.—

(1) IN GENERAL.—The Secretary shall take such steps as may be necessary to encourage and assist States to design and use magnetized medicaid identification cards that meet such standards, for use under their medicaid plans.

(2) LIMITATION ON MMIS FUNDS.—In applying section 1903(a)(3) of the Social Security Act, the Secretary may determine that Federal financial participation is not available under that section to a State which has provided for a magnetized card system that is inconsistent with the standards adopted under subsection (a).

(c) MEDICARE AND MEDICAID SECONDARY PAYER DATA BANK.—The Secretary shall establish a medicare and medicaid information system which is designed to provide information on those group health plans and other health benefit plans that are primary payers to the medicare program and medicaid program under section 1862(b) or section 1905(a)(25) of the Social Security Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in equal proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, a total of $25,000,000 to carry out subsections (a)

and (c), including the issuance of magnetized cards to medicare beneficiaries.

SEC. 262. PREEMPTION OF STATE QUILL PEN LAWS.

(a) IN GENERAL.—Effective January 1, 1994, no effect shall be given to any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic form.

(b) SECRETARIAL AUTHORITY.—The Secretary may issue regulations to carry out subsection (a). Such regulations may provide for such exceptions to subsection (a) as the Secretary determines to be necessary to prevent fraud and abuse, with respect to controlled substances, and in such other cases as the Secretary deems appropriate.

SEC. 263. USE OF STANDARD IDENTIFICATION NUMBERS.

(a) IN GENERAL.—Effective January 1, 1994, each health benefit plan shall—

(1) for each of its beneficiaries that has a social security account number, use that number as the personal identifier for claims processing and related purposes, and

(2) for each provider that has a unique identifier for purposes of title XVIII of the Social Security Act and that furnishes health care items or services

to a beneficiary under the plan, use that identifier as the identifier of that provider for claims processing and related purposes.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with standards established under subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirement of subsection (a), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such requirement with respect to such plans.

Subtitle D—Limitation of Antitrust Recovery for Certain Hospital Joint Ventures

SEC. 271. PURPOSE.

The purpose of this subtitle is to encourage cooperation among hospitals in order to contain costs and achieve a more efficient health care delivery system through the elimination of unnecessary duplication and proliferation of expensive high technology equipment, medical services, or ancillary services.

SEC. 272. DEFINITIONS.

For the purposes of this subtitle:

(1) The term ''antitrust laws'' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes—

(A) section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, and

(B) any State law similar to the antitrust laws.

(2) The term ''high technology equipment'' means equipment and devices utilized in medical

care, and the technical support systems for them, that—

(A) have acquisition costs greater than $1,000,000 or annual operating costs greater than $500,000, and

(B) use technologies with respect to which there is a reasonable expectation that shared ownership will avoid a significant degree of actual or anticipated excess capacity of service in the geographical area to be served.

(3) The term ''medical services'' means services that are involved in providing medical care to patients and that—

(A) have annual operating costs greater than $1,000,000, and

(B) with respect to which there is a reasonable expectation that shared ownership will avoid a significant degree of the actual or anticipated excess capacity of such services in the geographical area to be served,

and may include mobile services.

(4) The term ''ancillary services'' means support functions associated with operating a hospital (laundry, billing, patient transportation, data processing, and other similar services) the predominant

function of which does not involve the provision of medical treatment to patients.

(5) The term ''hospital'' means a hospital that—

(A) has entered into, and has in effect a participation agreement under section 1866(a) of the Social Security Act (42 U.S.C. 1395cc(a)), or

(B) has in effect a participation agreement under title XIX of such Act (42 U.S.C. 1396 et seq.) with the State in which the hospital is located.

(6) The term ''hospital joint venture'' means an agreement between 2 or more hospitals that is entered into solely for the purpose of sharing in the purchase or operation of high technology equipment, medical services, or ancillary services, and that involves substantial integration or financial risk-sharing between the parties. The term excludes—

(A) exchanging information among competitors relating to costs, sales, profitability, prices, marketing, or distribution of any product, process, or service that is not reasonably required to carry out such agreement,

(B) entering into any arrangement or engaging in any other conduct to restrict, require, or otherwise involve the marketing by any party to such agreement of any product, process, or service that is not reasonably required to carry out such agreement, and

(C) entering into any arrangement or engaging in any other conduct to restrict or require the participation by any party to such agreement in conduct that is not reasonably required to carry out such agreement.

(7) The term ''Attorney General'' means the Attorney General of the United States.

(8) The term ''Secretary'' means the Secretary of Health and Human Services.

(9) The term ''Commission'' means the Federal Trade Commission.

SEC. 273. LIMITATION ON DAMAGES FOR ANTITRUST VIOLATIONS.

Monetary recovery on a claim in any action brought under the antitrust laws against a hospital that is a party to a hospital joint venture shall be limited to actual damages if—

(1) the hospitals forming such venture meet the notification requirements specified in section 274,

(2) the claim results from conduct that is within the scope of the notification filed under section 274, and

(3) the action is filed after such notification becomes effective pursuant to section 274(c).

SEC. 274. DISCLOSURE OF HOSPITAL JOINT VENTURE.

(a) WRITTEN NOTIFICATIONS; FILING.—Any hospital that is a party to a hospital joint venture, acting on the venture's behalf, not later than 90 days after entering into a written agreement to form the venture, or not later than 90 days after, the date of the enactment of this Act, whichever is later, may file simultaneously with the Attorney General, the Secretary, and the Commission, a written notification disclosing—

(1) the identities of the parties to the venture, and

(2) the nature, objectives, and planned activity of the venture.

Any hospital that is a party to a hospital joint venture, acting on the venture's behalf, may file additional disclosure notifications pursuant to this section as are appropriate to extend the protections of section 273. In order to maintain the protections of section 273, the venture, not later than 90 days after a change in its membership or its planned activity, shall file simultaneously with the

Attorney General, the Secretary, and the Commission a written notification disclosing such change.

(b) PUBLICATION; FEDERAL REGISTER; NOTICE.—Not later than 30 days after receiving a notification filed under subsection (a), the Secretary, after consultation with the Attorney General and the Commission, shall publish in the Federal Register a notice with respect to the hospital joint venture that identifies the parties to the venture and that describes the planned activity of the venture. Prior to its publication, the contents of such notice shall be made available to the parties to the venture.

(c) EFFECT OF THE NOTICE.—If with respect to a notification filed under subsection (a) of this section, notice is published in the Federal Register, then such notification shall operate to convey the protections of section 273 as of the earlier of—

(1) the date of the publication of notice under subsection (b), or

(2) if such notice is not so published within the time required by subsection (b) of this section, after the expiration of the 30-day period beginning on the date that the Attorney General, the Secretary, or the Commission receives the applicable information described in subsection (a).

(d) EXEMPTION; DISCLOSURE; INFORMATION.—Except with respect to the information published pursuant to subsection (b)—

(1) all information and documentary material submitted as part of a notification filed pursuant to this section, and

(2) all other information obtained by the Attorney General, the Secretary, or the Commission in the course of any investigation, administrative proceeding, or case, with respect to a potential violation of the antitrust laws by the joint venture with respect to which such notification was filed,

shall be exempt from disclosure under section 552 of title 5, United States Code, and shall not be made publicly available by any agency of the United States to which such section applies, except as relevant to a law enforcement investigation or in a judicial or administrative proceeding in which such information and material is subject to any protective order.

(e) WITHDRAWAL OF NOTIFICATION.—Any party that files a notification pursuant to this section may withdraw such notification before notice of the hospital joint venture involved is published under subsection (b) of this section. Any notification so withdrawn shall not be subject

to subsection (b) and shall not confer the protections of section 273.

(f) JUDICIAL REVIEW: INAPPLICABLE WITH RESPECT TO NOTIFICATIONS.—Any action taken or not taken by the Attorney General, the Secretary, or the Commission with respect to notifications filed pursuant to this section shall not be subject to judicial review.

(g) ADMISSIBILITY INTO EVIDENCE: DISCLOSURE OF CONDUCT; PUBLICATION OF NOTICE; SUPPORTING OR ANSWERING CLAIMS UNDER ANTITRUST LAWS.—

(1) Except as provided in paragraph (2), the fact of disclosure of conduct under subsection (a) and the fact of publication of a notice under subsection (b) shall be admissible into evidence in any judicial or administrative proceeding for the sole purpose of establishing that a person is entitled to the protections of section 273.

(2) No action by the Attorney General, the Secretary, or the Commission taken pursuant to this section shall be admissible into evidence in any proceeding for the purpose of supporting or answering any claim under the antitrust laws.

Subtitle E—Medicaid Program Flexibility

SEC. 281. MODIFICATION OF FEDERAL REQUIREMENTS TO ALLOW STATES MORE FLEXIBILITY IN CONTRACTING FOR COORDINATED CARE SERVICES UNDER MEDICAID.

(a) IN GENERAL.—Section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended—

(1) by striking all that precedes paragraph (4) and inserting the following:

''(m) COORDINATED CARE.—

''(1) PAYMENT CONDITIONED ON COMPLIANCE.—

''(A) GENERAL RULE.—No payment shall be made under this title to a State with respect to expenditures incurred by it for payment to a risk contracting entity or primary care case management entity (as defined in subparagraph (B)), or with respect to an undertaking described in paragraph (6), unless the State and the entity or undertaking meet the applicable requirements of this subsection. For purposes of determining whether payment may be made under this section, the Secretary may reject a

State's determination of compliance with any provision of this subsection.

''(B) GENERAL DEFINITIONS.—For purposes of this title—

''(i) RISK CONTRACTING ENTITY.—The term 'risk contracting entity' means an entity that has a contract with the State agency under which the entity—

''(I) provides or arranges for the provision of health care items or services to individuals eligible for medical assistance under the State plan under this title, and

''(II) is at risk (as defined in clause (iv)) for part or all of the cost of such items or services furnished to such individuals.

''(ii) PRIMARY CARE CASE MANAGEMENT PROGRAM.—The term 'primary care case management program' means a State program under which individuals eligible for medical assistance under the State plan under this title are enrolled with primary care case management entities, and are entitled to receive specified health care items

and services covered under such plan only as arranged for and approved by such entities.

''(iii) AT RISK.—An entity is 'at risk', for purposes of this subparagraph, if it has a contract with the State agency under which it is paid a fixed amount for providing or arranging for the provision of specified health care items or services to an individual eligible for medical assistance and enrolled with the entity, regardless of whether such items or services are furnished to such individual, and is liable for all or part of the cost of furnishing such items or services, regardless of whether or the extent to which such cost exceeds such fixed payment.

''(iv) PRIMARY CARE CASE MANAGEMENT ENTITY.—The term 'primary care case management entity' means a health care provider (whether an individual or an entity) that, under a State primary care case management program meeting the requirements of paragraph (7), has a contract with the State agency under which

the entity arranges for or authorizes the provision of health care items and services to individuals eligible for medical assistance under the State plan under this title, but is not at risk (as defined in clause (iv)) for the cost of such items or services provided to such individuals.

''(2) GENERAL REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—

''(A) FEDERAL OR STATE QUALIFICATION.—Subject to paragraph (3), a risk contracting entity meets the requirements of this subsection only if it either—

''(i) is a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act, as determined by the Secretary pursuant to section 1312 of that Act, or

''(ii) is an entity which the State agency has determined—

''(I) affords, to individuals eligible for medical assistance under the State plan and enrolled with the entity, access to health care items and services furnished by the entity, with-

in the area served by the entity, at least equivalent to the access such individuals would have to such health care items and services in such area if not enrolled with the entity, and

''(II) has made adequate provision against the risk of insolvency, and assures that individuals eligible for medical assistance under this title are not held liable for the entity's debts in case of the entity's insolvency.

''(B) CONTRACT WITH STATE AGENCY.—Subject to paragraph (3), a risk contracting entity meets the requirements of this subsection only if the entity has a written contract with the State agency that provides—

''(i) that the entity will comply with all applicable provisions of this subsection;

''(ii) for a payment methodology based on experience rating or another actuarially sound methodology approved by the Secretary, which guarantees (as demonstrated by such models or formulas as the Secretary may approve) that payments to the

entity under the contract shall not exceed 100 percent of expenditures that would have been made by the State agency in the absence of the contract;

''(iii) that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain—

''(I) to the ability of the entity to bear the risk of potential financial losses, or

''(II) to services performed or determinations of amounts payable under the contract;

''(iv) that in the entity's reenrollment or disenrollment of individuals eligible for medical assistance under this title and eligible to reenroll or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

''(v)(I) that individuals eligible for medical assistance under the State plan

who have enrolled with the entity are permitted to terminate such enrollment without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination (or at such times as required pursuant to paragraph (8)), and

''(II) for notification of each such individual, at the time of the individual's enrollment, of the right to terminate enrollment;

''(vi) for reimbursement, either by the entity or by the State agency, for medically necessary services provided—

''(I) to an individual eligible for medical assistance under the State plan and enrolled with the entity, and

''(II) other than through the entity because the services were immediately required due to an unforeseen illness, injury, or condition;

''(vii) for disclosure of information in accordance with paragraph (4) and section 1124;

''(viii) in the case of an entity that has entered into a contract with a Federally-qualified health center for the provision of services of such center—

''(I) that rates of prepayment from the State are adjusted to reflect fully the rates of payment specified in section 1902(a)(13)(E), and

''(II) that, at the election of such center, payments made by the entity to such center for services described in section 1905(a)(2)(C) are made at the rates of payment specified in section 1902(a)(13)(E);

''(ix) that any physician incentive plan that the entity operates meets the requirements of section 1876(i)(8);

''(x) for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients; and

''(xi) that the entity complies with the requirement of section 1902(w) with respect to each enrollee.

''(3) EXCEPTIONS TO REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—The requirements of

paragraph (2) (other than subparagraph (B)(viii)) do not apply to an entity that—

''(A)(i) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title, has been the recipient of a grant under either such section; and

''(ii) provides to its enrollees, on a prepaid capitation or other risk basis, all of the services described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(10)(D) to be provided under the State plan, the services described in section 1905(a)(7);

''(B) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

''(i) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under

the Appalachian Regional Development Act of 1965), and

''(ii) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation or other risk basis; or

''(C) which has contracted with the State agency for the provision of services (but not including inpatient hospital services) to persons eligible for medical assistance under this title on a prepaid risk basis prior to 1970.''; and

(2) by adding after paragraph (6) the following new paragraphs:

''(7) GENERAL REQUIREMENTS FOR PRIMARY CARE CASE MANAGEMENT.—A State that elects in its State plan under this title to implement a primary care case management program under this

subsection shall include in the plan methods for the selection and monitoring of participating primary care case management entities to ensure that—

''(A) the numbers, geographic locations, hours of operation, and other relevant characteristics of such entities are sufficient to afford individuals eligible for medical assistance reasonable access to and choice among such entities;

''(B) such entities and their professional personnel are qualified to provide health care case management services, through methods including ongoing monitoring of compliance with applicable requirements for licensing of health care providers, providing training and certification of primary care case managers, and providing information and technical assistance; and

''(C) such entities are making timely and appropriate decisions with respect to enrollees' need for health care items and services, and are giving timely approval and referral to providers of adequate quality where such items and services are determined to be medically necessary.

''(8) STATE OPTIONS WITH RESPECT TO ENROLLMENT AND DISENROLLMENT.—

''(A) MANDATORY ENROLLMENT OPTION.—A State plan may require an individual eligible for medical assistance under the State plan (other than a medicare qualified beneficiary) to enroll with a risk contracting entity or primary care case management entity, without regard to the requirement of section 1902(a)(1) (concerning Statewideness), the requirements of section 1902(a)(10)(B) (concerning comparability of benefits), or the requirements of section 1902(a)(23) (concerning freedom of choice of provider), if the individual is permitted a choice—

''(i) between or among two or more risk contracting entities,

''(ii) between a risk contracting entity and a primary care case management entity, or

''(iii) between or among two or more primary care case management entities.

''(B)(i) RESTRICTIONS ON DISENROLLMENT WITHOUT CAUSE.—A State plan may restrict the period in which individuals enrolled with a qualifying risk contracting entity (as defined in clause (ii)) may terminate

such enrollment without cause to the first month of each period of enrollment (as defined in clause (iii)), but only if the State provides notification, at least once during each such enrollment period, to individuals enrolled with such entity of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.

''(ii) For purposes of this subparagraph, the term 'qualifying risk contracting entity' means a risk contracting entity that is—

''(I) a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act;

''(II) an eligible organization with a contract under section 1876;

''(III) an entity that is receiving (and has received during the previous 2 years) a grant of at least $100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act;

''(IV) an entity that is receiving (and has received during the previous 2 years)

at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965;

''(V) a program pursuant to an undertaking described in paragraph (6) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who (I) are not insured for benefits under part B of title XVIII or eligible for medical assistance under this title, and (II) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity; or

''(VI) an entity that, on the date of enactment of this provision, had a contract with the State agency under a waiver under section 1115 or 1915(b) and was not subject to a requirement under this subsection to permit disenrollment without cause.

''(iii) For purposes of this subparagraph, the term 'period of enrollment' means—

''(I) a period not to exceed 6 months in duration, or

''(II) a period not to exceed one year in duration, in the case of a State that, on the effective date of this subparagraph, had in effect a waiver under section 1115 of requirements under this title under which the State could establish a 1-year minimum period of enrollment with risk contracting entities.

''(C) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—In the case of an individual who—

''(i) in a month is eligible for medical assistance under the State plan and enrolled with a risk contracting entity with a contract under this subsection,

''(ii) in the next month (or next 2 months) is not eligible for such medical assistance, but

''(iii) in the succeeding month is again eligible for such benefits,

the State plan may enroll the individual for that succeeding month with such entity, if the entity continues to have a contract with the State agency under this subsection.''.

(b) STATE OPTION TO GUARANTEE MEDICAID ELIGIBILITY.—Section 1902(e)(2) of such Act (42 U.S.C. 1396a(e)(2)) is amended—

(A) in subparagraph (A), by striking all that precedes ''(but for this paragraph)'' and inserting ''In the case of an individual who is enrolled—

''(i) with a risk contracting entity (as defined in section 1903(m)(1)(B)(i)) responsible for the provision of inpatient hospital services and any other service described in paragraphs (2), (3), (4), (5), and (7) of section 1905(a),

''(ii) with any risk contracting entity (as so defined) in a State that, on the effective date of this provision, had in effect a waiver under section 1115 of requirements under this title under which the State could extend eligibility for medical assistance for enrollees of such entity, or

''(iii) with an eligible organization with a contract under section 1876 and who would'', and

(B) in subparagraph (B), by striking ''organization or'' each place it appears.

(c) CONFORMING AMENDMENTS.—

(1) Section 1128(b)(6)(C)(i) of such Act (42 U.S.C. 1320a–7(b)(6)(C)(i)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(2) Section 1902(a)(57) of such Act (42 U.S.C. 1396a(a)(57)) is amended by striking ''or health maintenance organization'' and inserting ''or risk contracting entity''.

(3) Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(A) by striking ''and'' at the end of paragraph (54);

(B) in the paragraph (55) inserted by section 4602(a)(3) of Public Law 101–508, by striking the period at the end and inserting a semicolon;

(C) by redesignating the paragraph (55) inserted by section 4604(b)(3) of Public Law 101–508 as paragraph (56), by transferring

and inserting it after the paragraph (55) inserted by section 4602(a)(3) of such Act, and by striking the period at the end and inserting a semicolon;

(D) by placing paragraphs (57) and (58), inserted by section 4751(a)(1)(C) of Public Law 101–508, immediately after paragraph (56), as redesignated by paragraph (3);

(E) in the paragraph (58) inserted by section 4751(a)(1)(C) of Public Law 101–508, by striking the period at the end and inserting a semicolon;

(F) by redesignating the paragraph (58) inserted by section 4752(c)(1)(C) of Public Law 101–508 as paragraph (59), by transferring and inserting it after the paragraph (58) inserted by section 4751(a)(1)(C) of such Act, and by striking the period at the end and inserting ''; and''; and

(G) by inserting after such paragraph (59) the following new paragraph:

''(60) at State option, provide for a primary care case management program in accordance with section 1903(m)(7).''.

(4) Section 1902(p)(2) of such Act (42 U.S.C. 1396a(p)(2)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(5) Section 1902(w) of such Act (42 U.S.C. 1396a(w)) is amended—

(A) in paragraph (1), by striking ''section 1903(m)(1)(A)'' and inserting ''section 1903(m)(2)(C)(xi)'', and

(B) in paragraph (2)(E), by striking ''health maintenance organization'' and ''the organization'' and inserting ''risk contracting entity'' and ''the entity'', respectively.

(6) Section 1903(k) of such Act (42 U.S.C. 1396b(k)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(7) Section 1903(m)(4)(A) of such Act (42 U.S.C. 1396b(m)(4)(A)) is amended—

(A) in the first sentence, by striking ''Each health maintenance organization'' and inserting ''Each risk contracting entity'',

(B) in the first sentence, by striking ''the organization'' each place it appears and inserting ''the entity'', and

(C) in the second sentence, by striking ''an organization'' and ''the organization'' and inserting ''a risk contracting entity'' and ''the risk contracting entity'', respectively.

(8) Section 1903(m)(4)(B) of such Act (42 U.S.C. 1396b(m)(4)(B)) is amended by striking ''organization'' and inserting ''risk contracting entity''.

(9) Section 1903(m)(5) of such Act (42 U.S.C. 1396b(m)(5)) is amended in paragraphs (A)(iii) and (B)(ii) by striking ''organization'' and inserting ''entity''.

(10) Section 1903(w)(7)(A)(viii) of such Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended by striking ''health maintenance organizations (and other organizations with contracts under section 1903(m))'' and inserting ''risk contracting entities with contracts under section 1903(m)''.

(11) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter preceding clause (i), by inserting ''(which may be on a prepaid capitation or other risk basis)'' after ''payment'' the first place it appears.

(12) Section 1916(b)(2)(D) of such Act (42 U.S.C. 1396o(b)(2)(D)) is amended by striking

''health maintenance organization'' and inserting ''risk contracting entity''.

(13) Section 1925(b)(4)(D)(iv) of such Act (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended—

(A) in the heading, by striking ''HMO'' and inserting ''RISK CONTRACTING ENTITY'',

(B) by striking ''health maintenance organization'' and inserting ''risk contracting entity'' each place it appears, and

(C) by striking ''section 1903(m)(1)(A)'' and inserting ''section 1903(m)(1)(B)(i)''.

(14) Paragraphs (1) and (2) of section 1926(a) of such Act (42 U.S.C. 1396r–7(a)) are each amended by striking ''health maintenance organizations'' and inserting ''risk contracting entities''.

(15) Section 1927(j)(1) of such Act (42 U.S.C. 1396s(j)(1)) is amended by striking ''*** Health Maintenance Organizations, including those organizations'' and inserting ''risk contracting entities''.

(d) EFFECTIVE DATE.—The amendments made by this section shall become effective with respect to calendar quarters beginning on or after January 1, 1994.

SEC. 282. PERIOD OF CERTAIN WAIVERS.

(a) IN GENERAL.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended by striking

''No waiver'' and all that follows through ''unless the Secretary'' and inserting ''A waiver under this section (other than under subsection (c), (d), or (e)) shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5 year periods unless the Secretary''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to waivers pursuant to applications which are approved, and with respect to continuations of waivers for which requests are made, later than 30 days after the date of the enactment of this Act.

TITLE III—REFUNDABLE CREDIT FOR COSTS OF PROVIDING EMERGENCY INDIGENT CARE

SEC. 301. REFUNDABLE CREDIT FOR COSTS OF PROVIDING EMERGENCY INDIGENT CARE.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

''SEC. 35. COSTS OF PROVIDING EMERGENCY INDIGENT CARE.

''(a) ALLOWANCE OF CREDIT.—There shall be allowed as a credit against the tax imposed by this subtitle

for the taxable year an amount equal to 15 percent of the unreimbursed eligible costs incurred by the taxpayer in providing emergency health care services.

''(b) DEFINITIONS.—For purposes of this section—

''(1) UNREIMBURSED ELIGIBLE COSTS.—The term 'unreimbursed eligible costs' means costs—

''(A) which are recognized as reasonable for purposes of payment under title XVIII of the Social Security Act, and

''(B) for which the taxpayer (other than as an employee) is entitled to reimbursement.

''(2) EMERGENCY HEALTH CARE SERVICES.—The term 'emergency health care services' means medical screening, examination, and treatment provided to an individual pursuant to the requirements of subsections (a) and (b)(1) of section 1867 of the Social Security Act but only if the individual has no coverage under a health insurance or health benefit plan with respect to the screening, examination, or treatment.

''(c) SPECIAL RULES.—For purposes of this section—

''(1) UNREIMBURSED COSTS.—Costs shall be treated as unreimbursed not earlier than the time such costs would be allowable as a deduction under

section 166 were the obligation to pay such costs a debt to which section 166 applies.

''(2) NO CREDIT FOR DEDUCTIBLE WORTHLESS DEBTS.—No credit shall be allowed under this section for any debt which would be allowable as a deduction under section 166 if the debt became worthless.

''(d) PAYMENTS TO TAX-EXEMPT ENTITIES.—

''(1) IN GENERAL.—In the case of a tax-exempt entity, in lieu of the credit under subsection (a), the Secretary shall pay the amount determined under this section if claim therefor is filed at such time and in such manner as the Secretary may prescribe.

''(2) TAX-EXEMPT ENTITY.—For purposes of paragraph (1), the term 'tax-exempt entity' means—

''(A) a State, a political subdivision of a State, the District of Columbia, any possession of the United States, and an agency or instrumentality of 1 or more of the foregoing, and

''(B) an organization exempt from tax under section 501(a) (other than an organization required to make a return of tax imposed under this subtitle).''

(b) CLERICAL AMENDMENT.—The table of sections for such subpart C is amended by striking the last item and inserting the following new items:

''Sec. 35. Costs of providing emergency indigent care.
''Sec. 36. Overpayments of tax.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to costs incurred with respect to emergency health care services provided on or after the 1st day of the 1st calendar month which begins more than 60 days after the date of the enactment of this Act in taxable years ending after such date.

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